

PUBLIC CHAPTER NO. 1190

SENATE BILL NO. 4181

By Lowe Finney, Black, Kyle, Berke, Marrero, Raymond Finney, Norris, Beavers, Bunch, Burchett, Burks, Crowe, Ford, Harper, Haynes, Henry, Herron, Jackson, Johnson, Ketron, Kilby, Kurita, McNally, Roller, Southerland, Stanley, Tate, Tracy, Watson, Wilder, Williams, Woodson, Mr. Speaker Ramsey

Substituted for: House Bill No. 4144

By Ferguson, Odom, Lois DeBerry, Mr. Speaker Naifeh, Casada, Harmon, Curtiss, Shepard, Vaughn, John Deberry, Rinks, Hawk, Ford, Harrison, Roach, Harwell, Towns, West, Hardaway, Buck, Miller, Overbey, Mike Turner, Yokley, Moore, Winningham, Hackworth, Cooper, Kernell, Sherry Jones, Borchert, Fraley, Bone, Bibb, Fitzhugh, Shaw, Dunn, Bell, Baird, Sargent, Favors, Ulysses Jones, Hood, Tidwell, Armstrong, Litz, Maddox, Gilmore, Pruitt, Williams, Sontany, Bass, Richardson, Jim Cobb, Pinion, Maggart, Crider, McDaniel, Hensley, Eldridge, Curt Cobb, Lollar, Lundberg, Brown, Watson, Coley, Camper, Swafford, Kelsey, DuBois, Todd, Curtis Johnson, Niceley, McDonald, Montgomery, Campfield, Mumpower, Hill, Phillip Johnson, Coleman, McManus, Gresham, Harry Brooks, Windle, Fincher

AN ACT to amend Tennessee Code Annotated, Title 63 and Title 68 and 71, relative to long-term care.

WHEREAS, in Tennessee, the current long-term care system for persons who are elderly and/or adults with physical disabilities is fragmented, with access to the various types of long-term care services scattered across different points of entry with no coordination between services, making it difficult for people who need care and their families to understand their options, make informed decisions, and access services in a timely manner; and

WHEREAS, people who need long-term care and their families have little opportunity to exercise any choice or decision-making with respect to the types of long-term care services they need and who will provide them; and

WHEREAS, the current long-term care system is heavily dependent on the most costly services with 98 percent of long-term care funding spent on institutional care and limited utilization of lower cost home and community-based options even though such options would better meet the needs and preferences of people who need care and their families; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 14, is amended by deleting the language in Sections 71-5-1401 through 1406 and Section 71-5-1409 in their entirety, adding the following language as new, appropriately designated sections, and renumbering remaining sections accordingly.

SECTION 2. The title of this act is, and may be cited as, the "Long-Term Care Community Choices Act of 2008".

SECTION 3. (a) The long-term care system shall recognize that aging is not a disease, but rather a natural process that often includes increasing needs for assistance with daily living activities. To the maximum extent possible and appropriate, the system shall be based on a model of care delivery which acknowledges that services delivered in home and community-based settings are not primarily medical in nature, but rather, support services that will provide needed assistance with activities of daily living and that will allow persons to "age in place" in their homes and communities.

(b) The long-term care system shall also recognize that persons who are elderly and/or who have physical disabilities are more likely to have chronic health care conditions and to need preventive, acute, and chronic health care services in order to promote healthy living and improve quality of life. The system shall be designed to focus on the needs of the "whole person", with coordination of care across the continuum to ensure that medical, behavioral and non-medical long-term care support needs are met.

(c) The long-term care system shall promote independence, choice, dignity, and quality of life for elderly and/or people with physical disabilities who need long-term care supports and services and shall include consumer-directed options that offer more choices regarding the kinds of long-term care services people need, where they are provided, and who will deliver them, with appropriate mechanisms to ensure accountability for taxpayer funds.

(d) The long-term care system shall be designed to reduce fragmentation and to offer a seamless approach to meeting people's needs, including one-stop shopping for information, counseling and assistance regarding long-term care programs in order to support informed decision making, simplified eligibility processes, and one-stop shopping for all of the different kinds of services a person may need.

(e) The long-term care system shall recognize and value the critical role of the family and other caregivers in meeting the needs of the elderly and people with physical disabilities and shall offer services such as caregiver training, adult daycare, and respite that "wrap around" the natural support network in order to keep it in place, thereby delaying or preventing the need for more expensive, institutional care.

(f) The long-term care system shall deliver needed supports and services in the most integrated setting appropriate and cost-effective way possible in order to utilize available funding to serve as many people as possible in home and community settings.

(g) The long-term care system shall utilize a global budget for all long-term care services for persons who are elderly or who have physical disabilities that allows funding to follow the person into the most appropriate and cost-effective long-term care setting of their choice, resulting in a more equitable balance between the proportion of Medicaid long-term care expenditures for institutional (i.e., nursing facility) services and expenditures for home and community-based services and supports.

(h) The long-term care system shall offer a continuum of long-term care services which includes an expanded array of home and community-based options including community-based residential alternatives to institutional care for persons who can no longer live alone, and which also includes nursing facility services as an integral part of the long-term care continuum for persons with the highest levels of need.

(i) The long-term care system shall include a comprehensive quality approach across the entire continuum of long-term care services and settings that promotes continuous quality improvement and that focuses on customer perceptions of quality, with mechanisms to ensure ongoing feedback from persons receiving care and their families in order to immediately identify and resolve issues, and to improve the overall quality of services and the system.

SECTION 4. As used in this act, unless the context otherwise requires:

(1) "Budget Allowance" means the amount of money that can be directed, utilizing the services of a fiscal intermediary, by a Medicaid-eligible long-term care member participating in this consumer-directed care option, to pay for home and community-based long-term care services defined under the Medicaid state plan or any federal waivers or amendments thereto that are necessary to meet the member's long-term care needs and to delay or prevent institutionalization. The budget allowance shall be based on the results of a functional assessment performed by a qualified entity and the availability of family and other caregivers who can help provide needed support, and when combined with the cost of home health services and private duty nursing in the home or other community-based setting, cannot exceed the cost of institutional care;

(2) "Commissioner" means the Commissioner of Finance and Administration or the commissioner's designee;

(3) "Cost-Effective" means that the total cost of services provided to an eligible elderly or physically disabled adult in the home or other community-based setting does not exceed the cost of reimbursement for institutional care in a nursing facility. The total cost of services shall

include the cost of home health services and private duty nursing, as well as home and community-based long-term care services provided pursuant to the Medicaid state plan or any federal waiver or amendments thereto.

(4) "Fiscal Intermediary" means an entity with whom the commissioner or a contractor responsible for the coordination of Medicaid primary, acute and long-term care services has contracted to help a member participating in this consumer-directed care option manage the member's budget allowance. The fiscal intermediary will manage all payments to providers and paid caregivers for specified home and community-based services on behalf of the member, process employment and tax information as applicable, review records to ensure accuracy and provide full accountability for all expenditures made on behalf of each participating member.

(5) "Qualified Entity" means an entity with which the commissioner has contracted to assess the needs of persons determined medically eligible for long-term care services and to develop care plans to address their identified needs. Such entity shall have the expertise and capacity to timely perform these services and shall not provide any direct long-term care service which may create a conflict of interest. A managed-care organization performing care coordination services under this act shall be a qualified entity only to the extent that appropriate regulatory and contractual safeguards are in place to help ensure that such assessment and care plan development processes are fair, objective and consistent with the needs of the individual and his or her family caregivers, as applicable.

(6) "Rebalance" means reaching a more equitable balance between the proportion of Medicaid long-term care expenditures used for institutional (i.e., Nursing Facility) services and those used for home and community-based services and supports under the Medicaid state plan or federal waivers or amendments thereto.

SECTION 5. (a) The commissioner shall develop and implement a statewide fully integrated risk-based long-term care system which integrates Medicaid-reimbursed primary, acute and long-term care services, building in strong consumer protections and aligning incentives to ensure that the right care is delivered in the right place at the right time. The long-term care system shall rebalance the overall allocation of funding for Medicaid-reimbursed long-term care services by expanding access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals. Such system may include, subject to the availability of funding in each year's appropriations bill, expansion of PACE (Programs of All Inclusive Care for the Elderly) sites in additional major metropolitan areas of the state.

(b) The commissioner shall ensure that comprehensive, person-centered care coordination across all Medicaid primary, acute and long-term care services is a central component of the integrated long-term

care system and the contractor risk agreement. A qualified entity shall conduct a comprehensive individualized assessment of needs in accordance with protocols developed by the commissioner, and shall develop a care plan with active participation of the member and family or other caregivers that addresses the identified needs and builds on and does not supplant family and other caregiving supports. The entity responsible for care coordination shall cost-effectively implement the care plan; assure coordination and monitoring of all Medicaid primary, acute and long-term care services to assist individuals and family or other caregivers in providing and securing necessary care; and assure the availability of a qualified workforce, including backup workers when necessary, to timely provide necessary services.

(c) Nothing herein may be construed to create an entitlement to home and community-based services; provided, however, the commissioner shall design and implement the integrated long-term care system in a manner that affords access to the appropriate level of cost-effective home and community-based services for the greatest number of Medicaid-eligible elderly and/or physically disabled individuals possible, subject to the availability of funding in each year's appropriation bill.

(d) The cost of home and community-based services provided to a Medicaid-eligible individual, which includes the cost of home health services and/or private duty nursing to the extent covered under the Medicaid program, shall not exceed the cost of institutional services for that individual in a nursing facility except as permitted under the current Medicaid state plan or any federal waivers or amendments thereto.

SECTION 6. The commissioner shall ensure that there is a single entry point into the long-term care system that is responsible for ensuring that persons seeking care and their families have access to readily available, easy-to-understand information about long-term care options. Functions performed by the single entry point may include counseling and assistance in evaluating long-term care options, screening and intake for long-term care programs, facilitated enrollment for Medicaid financial eligibility and assistance with evaluation of level of care in order to facilitate determination of medical eligibility for Medicaid long-term care services. Activities performed by the single entry point shall be conducted based on clear and consistent policies, processes and timelines in order to expedite access to available long-term care programs and services. To ensure the most seamless and efficient system possible, Medicaid-eligible persons shall not be required to go back through the single entry point in order to access long-term care services, but rather, shall have a single entity that is responsible for coordinating all of the Medicaid benefits the member may need, including medical, behavioral, nursing facility, and home and community-based services.

SECTION 7. The commissioner shall implement policies and processes that expedite the determination of Medicaid categorical and financial eligibility and medical eligibility for home and community-based programs and services, either through contracted functions of the Department of Human Services or within the Bureau of TennCare. Such policies and processes may include, but

are not limited to, presumptive or immediate Medicaid eligibility determination, fast-track eligibility determination, development of specialized units or teams for determination of Medicaid eligibility for HCBS, implementation of facilitated enrollment processes, and the implementation of an online medical eligibility application process.

SECTION 8. (a) The commissioner shall develop level of care criteria for new nursing facility admissions which ensure that the most intensive level of long-term care services is provided to persons with the highest level of need. The Bureau of TennCare shall define the state's medical eligibility criteria for all long-term care services, including nursing facility and home and community-based waiver services. The Bureau of TennCare shall develop the Pre Admission Evaluation (PAE) assessment tool, and shall make the determination of medical eligibility for long-term care services.

(b) Nursing facility residents who meet continued stay criteria and who remain financially eligible for Medicaid shall continue to be eligible to receive nursing facility services or cost-effective home and community-based waiver services, and shall not be required to meet new nursing facility level-of-care criteria.

(c) Current enrollees in the statewide home and community-based services waiver program for persons who are elderly and/or adults with physical disabilities who meet continued stay criteria and remain financially eligible for Medicaid shall continue to be eligible to receive cost-effective home and community-based waiver services and shall not be required to meet new nursing facility level-of-care criteria except for admission to a nursing facility.

(d) The commissioner shall develop and seek approval of a waiver application or amendment thereto which allows persons who meet a lesser level of care, i.e., who do not meet new nursing facility level-of-care criteria, but are "at risk" of institutional care, to qualify for a more moderate package of Medicaid-reimbursed home and community-based waiver services up to a specified enrollment cap.

SECTION 9. (a) The commissioner shall develop and implement strategies to encourage the utilization of cost-effective home and community-based services in lieu of institutional placement.

(b) The commissioner shall specify in contractor risk agreements with integrated long-term care contractors requirements related to nursing facility diversion. Such requirements may include, but are not limited to, the following:

(1) documentation prior to approval of nursing facility admission that an individual and his/her family or other caregivers have been advised of home and community-based alternatives and that such alternatives are not appropriate, cost-effective, or desired; and

(2) a requirement for care coordinators to work with hospital discharge planners and to provide face-to-face visits in nursing facilities within a minimum number of days following admission to develop a plan, as appropriate, for transition back to a home or community-based setting.

SECTION 10. (a) The commissioner shall develop and implement a nursing facility transition initiative.

(b) The commissioner shall specify in contractor risk agreements with contractors responsible for coordination of Medicaid primary, acute and long-term care services requirements related to nursing facility-to-community transitions.

(c) Contractor requirements shall include identification of nursing facility residents who may be appropriate for transition to home and community-based settings, as well as assessment and care plan development by a qualified entity. The contractor shall plan and facilitate such transitions in a timely manner. Contractors shall be permitted to coordinate or subcontract with local community-based organizations to assist in the identification, planning and facilitation processes, and may offer, as a cost-effective alternative to continued institutional care, a per-person transition cost allowance not to exceed two thousand dollars (\$2,000) for items such as, but not limited to, first month's rent, rent deposits, utility deposits, kitchen appliances, furniture and basic household items.

(d) It is the legislative intent of this section to provide more opportunities for home and community-based services for the at-risk population, subject to the availability of funding in each year's appropriations bill.

SECTION 11. (a) The commissioner shall develop and implement strategies to assist nursing facilities in diversifying their lines of business, including provision of home and community-based services and specialized nursing facility care to meet the targeted needs of chronic care populations.

(b) Such strategies may include, but are not limited to, provision of training and technical assistance; streamlined provider enrollment processes for home and community-based services, and development of special acuity-based rates to meet the more intensive caregiving demands of certain chronic care populations, subject to the availability of funding in each year's appropriations bill.

SECTION 12. (a) The commissioner shall develop and implement a plan to expand cost-effective community-based residential alternatives to institutional care for persons who are elderly and/or adults with physical disabilities, which may include, but are not limited to, the development of multiple levels of assisted-care living facility services, adult family care

homes, adult foster care homes, companion care models, and other cost-effective residential alternatives to nursing facility care.

(b) The commissioner and the board for licensing health care facilities shall work to develop and/or modify licensure requirements for such facilities to support a nursing facility substitute framework for members who want to age in place in residences that offer increasing levels of cost-effective home and community-based care as an alternative to institutionalization as member's needs change.

SECTION 13. (a) The Bureau of TennCare shall require that any managed care organization (MCO) contract with all current nursing facility providers for a transition period of at least three (3) years following implementation of the managed long-term care service delivery system or four (4) years from the effective date of this act.

(b) For purposes of this section, "current nursing facility providers" are those nursing facility providers that meet the federal statutory definition of a "nursing facility" as defined at Section 1919(h) of the Social Security Act and its implementing regulations, and which fully satisfy one or more of the following three (3) conditions:

(1) the nursing facility has a signed TennCare Medicaid provider agreement for the delivery of nursing facility services on the effective date of this act;

(2) the nursing facility had a signed TennCare Medicaid provider agreement for the delivery of nursing facility services as of January 1, 2007, did not voluntarily withdraw from participation in the Medicaid program, and has requested recertification as a Medicaid and/or Medicare provider by the Centers for Medicare and Medicaid Services as of the effective date of this act; or

(3) the nursing facility has applied for or received an approved certificate of need for a new or replacement facility as of the effective date of this act.

(c) MCOs may, but shall not be required to contract with nursing facility providers that meet the federal statutory definition of a "nursing facility" as defined at Section 1919(h) of the Social Security Act and its implementing regulations, but which do not fully satisfy one or more of the conditions specified in (b)(1) through (3) above.

SECTION 14. (a) The commissioner shall develop and implement an acuity-based reimbursement methodology for nursing facility services, based on an individualized assessment of need, as an alternative to the current cost-based nursing facility reimbursement system.

(b) Such methodology may include, but is not limited to, the development of enhanced rates for specified chronic care services which may encourage the establishment of chronic care units that specialize in

the care of persons with specified chronic care conditions such as persons who are ventilator-dependent.

(c) The acuity-based reimbursement methodology for nursing facility services shall be implemented over a period not to exceed two (2) years from the initial date of implementation of such system or three (3) years from the effective date of this act pursuant to a methodology established in regulations promulgated by the commissioner.

SECTION 15. (a) The commissioner shall, upon approval of a waiver amendment granting authority from the federal government, develop and make available consumer-directed options for persons receiving home and community-based long-term care services under the long-term care program, which may include, but are not limited to, the ability to select, direct, and/or employ persons delivering unskilled hands-on or support services such as personal care services, personal care assistant/attendant, homemaker services, in-home respite, the ability to direct and supervise a paid personal aide in the performance of a health care task, and the ability to manage, utilizing the services of a fiscal intermediary, an individual home and community-based services budget allowance based on functional assessment performed by a qualified entity and the availability of family and other caregivers who can help provide needed support.

(b) Members eligible to receive home and community-based long-term care pursuant to this act may, subject to regulations promulgated by the commissioner, be permitted to use the budget allowance to direct payment, utilizing the services of a fiscal intermediary, for those home and community-based services that are necessary to meet the member's long-term care needs and to prevent and/or delay institutionalization and which are a cost-effective use of long-term care funds. Such services shall include only those services which are permitted under the Medicaid state plan or any federal waivers or amendments thereto.

(c) Notwithstanding any provision of law or rule to the contrary, a competent adult with a functional disability living in his or her own home or a caregiver acting on behalf of a minor child or incompetent adult living in his or her own home may choose to direct and supervise a paid personal aide in the performance of a health care task.

(d) For purposes of this section, a competent adult is a person age 18 or older who has the capability and capacity to evaluate knowledgeably the options available and the risks attendant upon each and to make an informed decision, acting in accordance with his or her own preferences and values. A person is presumed competent unless a determination to the contrary is made.

(e) For purposes of this section, a caregiver is a person who is (1) directly and personally involved in providing care for a minor child or incompetent adult; and (2) is the parent, foster parent, family member, friend, or legal guardian of such minor child or incompetent adult.

(f) For purposes of this section, a person's home is the dwelling in which the person resides, whether the person owns, leases, or rents such residence, or whether the person resides in a dwelling owned, leased, or rented by someone else. A person's home may include specified community-based residential alternatives to nursing facility care as promulgated in rules and regulations by the commissioner, but shall not include a nursing facility or assisted-care living facility setting.

(g) For purposes of this section, a paid personal aide is any person providing paid home care services, such as personal care or homemaker services, which enable the person receiving care to remain at home whether such paid personal aide is employed by the person receiving care, a caregiver, or by a contracted provider agency that has been authorized to provide home care services to that person.

(h) For purposes of this section, health care tasks are those medical, nursing, or home health services, beyond activities of daily living, which (1) a person without a functional disability or a caregiver would customarily and personally perform without the assistance of a licensed health care provider; (2) the person is unable to perform for himself or herself due to a functional or cognitive limitation; (3) the treating physician, advanced practice nurse, or registered nurse determines can be safely performed in the home and community by a paid personal aide acting under the direction of a competent adult or caregiver; and (4) enable the person to maintain independence, personal hygiene, and safety in his or her own home.

(i) The individual or caregiver who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves the health care task of the individual or caregiver's intent to perform that task through self-direction.

(j) When a licensed health care provider orders treatment involving a health care task to be performed through self-directed care, the responsibility to ascertain that the patient or caregiver understands the treatment and will be able to follow through on the self-directed care task is the same as it would be for a patient or caregiver who performs the health care task for himself or herself, and the licensed health care provider incurs no additional liability when ordering a health care task which is to be performed through self-directed care.

(k) The role of the personal aide in self-directed care is limited to performing the physical aspect of health care tasks under the direction of the person for whom the tasks are being done or that person's caregiver. This shall not affect the ability of a personal aide to provide other home care services, such as personal care or homemaker services, which enable the person to remain at home.

(l) The responsibility to initiate self-directed health care tasks, to possess the necessary knowledge and training for those tasks, and to

exercise judgment regarding the manner of their performance rests and remains with the person or caregiver who has chosen to self-direct those tasks, including the decision to employ and dismiss a personal aide, or to decide that a personal aide will no longer perform a health care task.

(m) A description of health care tasks to be performed through self-directed care will be included in the person's care plan.

(n) The commissioner shall promulgate rules which define the qualifications, training, and oversight requirements for self-direction of health care tasks. The commissioner shall develop such rules with input from licensed health care professionals, including but not limited to, representatives of the nursing and medical professions, as well as persons with functional limitations, caregivers and home and community-based services providers.

SECTION 16. The commissioner shall develop and implement quality assurance and quality improvement strategies to ensure the quality of long-term care services provided pursuant to this act and shall specify in contractor risk agreements with contractors responsible for coordination of Medicaid primary, acute and long-term care services requirements related to the quality of long-term care services provided. Such strategies may include the use of electronic visit verification for data collection and reporting, HEDIS measures pertaining to long-term care services, and shall include mechanisms to ensure direct feedback from members and family or other caregivers regarding the quality of services received. The commissioner shall ensure that recipients of long-term care services are notified how to contact the Bureau of TennCare if they have concerns about the long-term care services they are or are not receiving, and the process for resolving such issues.

SECTION 17. Subject to the availability of funding, the commissioner shall designate in each year's appropriations bill an amount of money that can be used to increase access to home and community-based services in the state-funded Options program for persons who do not qualify for Medicaid long-term care services. This funding may be used to provide services such as home-delivered meals, homemaker services and personal care, and to reduce the waiting list for these services under the Options program, or to offer transportation services or assistance to non-Medicaid-eligible individuals.

SECTION 18. The commissioner shall provide Medicaid long-term care services subject to the availability of funding in each year's appropriations bill.

SECTION 19. Tennessee Code Annotated, Section 71-5-105(a)(3), is amended by adding the following new subdivision:

(D) Upon passage of any law authorizing the promulgation of rules establishing an acuity-based reimbursement methodology for nursing facility care, the per diem cost reimbursement methodology set forth in subdivisions (B) and (C) shall be phased out in accordance with such regulations establishing an acuity-based reimbursement methodology,

and shall be inapplicable upon the full implementation of such acuity-based reimbursement methodology.

SECTION 20. Except as otherwise specified herein, the commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act compiled at Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 21. Tennessee Code Annotated, Section 68-11-201(4), is amended by deleting the language in its entirety and by substituting instead the following language:

(4) The purpose of assisted-care living facility services is to promote the availability of residential alternatives to institutional care for persons who are elderly or who have disabilities in the least restrictive and most homelike environment appropriate. Assisted-care living facility services shall be driven by a philosophy that emphasizes personal dignity, respect, autonomy, independence, and privacy and should, to the maximum extent appropriate, enhance the person's ability to age in place, while also ensuring that the person's medical and other needs are safely and effectively met.

(A) "Assisted-care living facility" means a facility, building, establishment, complex or distinct part thereof which accepts primarily aged person for domiciliary care and services as described in this section.

(B) An assisted-care living facility shall provide on site to its residents room and board, and non-medical living assistance services appropriate to each resident's needs, such as assistance with bathing, dressing, grooming, preparation of meals and other activities of daily living.

(C) Subject to limitations specified herein, an assisted-care living facility may also provide onsite to its residents administration of medications that are typically self-administered, excluding intravenous injections except as permitted pursuant to Sections (5)(D) and (5)(E), and all other medical services as prescribed by each resident's treating physician that could be provided to a private citizen in his or her own home by an appropriately licensed or qualified health care professional or entity, such as part-time or intermittent nursing care, various therapies including physical, occupational and speech therapy, podiatry care, medical social services, medical supplies other than drugs and biologicals, durable medical equipment, and hospice services.

(i) Such medical services that may be provided in the assisted-care living facility must be provided by appropriately licensed or qualified staff or contractors of the assisted-care living facility, a licensed home care

organization, another appropriately licensed entity, or by the appropriately licensed staff of a nursing home, acting within the scope of their respective licenses.

(ii) Nothing in this subdivision (4) shall authorize assisted-care living facilities to provide medical services to assisted-care living facility residents if such services are reimbursable under the federal Medicare program.

(iii) Oversight of medical services provided by licensed health care professionals and entities in an assisted-care living facility shall be provided in a manner that is consistent with the oversight of services provided by such licensed health care professionals or entities in private residential settings as defined through rules and regulation promulgated by the applicable licensing board and as may be further defined through rules and regulations promulgated by the board for licensing health care facilities pursuant to this section to ensure the quality of care received.

(iv) The assisted-care living facility shall be responsible for the development of a plan of care that ensures the safety and well-being of the resident's living environment and for the provision of the resident's health care needs. Furthermore, any licensed health care professional or entity that is delivering services to the resident in the assisted-care living facility shall be available to assist in the plan of care development and to assess, plan, monitor, direct and evaluate the resident's care in conjunction with the resident's physician and in cooperation with the assisted-care living facility.

(v) Assisted-care living facilities shall be subject to licensure and must meet such requirements and minimum standards as the board prescribes in regulations pursuant to Tennessee Code Annotated, Section 68-11-209. In the regulations, the board shall specifically address the needs of residents who may receive medical services provided pursuant to this part including documentation of physician orders, and nursing and treatment records of all medical services provided in the assisted-care living facility in an appropriate medical record maintained by the facility regardless of whether the services are rendered by appropriately licensed or qualified staff of the assisted-care living facility or by arrangement with an outside entity.

(vi) The board shall also, in consultation with the state fire marshal, include in such regulations fire safety standards that afford reasonable protection to assisted-

care living facility residents without unduly disturbing the residential atmosphere to which they are accustomed.

SECTION 22. Tennessee Code Annotated, Section 68-11-201(5), is amended by deleting the language in its entirety and by substituting instead the following language:

(5) "Assisted-care living facility resident" means primarily an aged person who requires domiciliary care, and who upon admission to the facility, if not ambulatory, is capable of self-transfer from the bed to a wheelchair or similar device and is capable of propelling such wheelchair or similar device independently. Such resident may require one (1) or more of the services described in subdivision (4).

(A) An assisted-care living facility resident shall be transferred to a licensed hospital, licensed nursing home or other appropriate setting if the resident, the appropriate person with legal authority to make such decisions on behalf of the resident, the assisted-care living facility administrator, or the resident's treating physician determine that the services available to the resident in the assisted-care living facility, including medical services provided pursuant to Section (4)(C), will not safely and effectively meet the resident's needs. This provision shall not be interpreted as limiting the authority of the board or the department to require the transfer or discharge of individuals to different levels of care as required by statute when the resident's needs cannot be safely and effectively met by care provided in the assisted-care living facility, including medical services provided pursuant to Section (4)(C).

(B) Subject to limitations specified in Sections (5)(C) and (D) below, an assisted-care living facility may admit and permit the continued stay of a person who meets medical eligibility, i.e., level of care requirements for nursing facility services as defined by the Bureau of TennCare, so long as the person's treating physician certifies that the person's needs can be safely and effectively met by care provided in the assisted-care living facility, including medical services provided pursuant to Section (4)(C), and the assisted-care living facility can provide assurance of timely evacuation in a fire or emergency.

(C) Assisted-care living facilities shall not admit nor permit the continued stay of:

(i) A person requiring treatment for a stage III or IV decubitus ulcer or with exfoliative dermatitis;

(ii) A person who requires continuous nursing care. For purposes of this section, "continuous nursing care" means round-the-clock observation, assessment,

monitoring, supervision, or provision of nursing services that can only be performed by a licensed nurse;

(iii) A person who has an active, infectious and reportable disease in a communicable state that requires contact isolation;

(iv) A person whose verbal or physical aggressive behavior poses an imminent physical threat to himself or herself or others, based not on the person's diagnosis, but on the behavior of the person;

(v) A person requiring physical or chemical restraints, not including psychotropic medications prescribed for a manageable mental disorder or condition; or

(vi) A person whose needs cannot be safely and effectively met in the assisted-care living facility.

(D) Assisted-care living facilities shall not admit, but may permit the continued stay in the facility of existing residents who require the treatments specified below only on an intermittent basis or who are receiving hospice care from an appropriately licensed provider, as permitted pursuant to Section (5)(E) below. If such treatments are intermittent and extend beyond twenty-one (21) days, no more than two (2) additional twenty-one (21)-day extensions may be granted by the assisted-care living facility provided that the resident's treating physician certifies that the person's intermittent need for such treatment can be safely and effectively met by care provided in the assisted-care living facility, including medical services provided pursuant to Section (4)(C). Assisted-care living facilities shall not permit the continued stay in the facility of existing residents who require such treatments on an ongoing, rather than intermittent basis, unless a resident who requires such treatments on an ongoing basis does not qualify for nursing facility level of care, in which case a waiver may be granted by the board for licensing health care facilities, allowing the person to remain in the assisted-care living facility. A person who requires any of the treatments specified below and who is able to self-care for such person's condition without the assistance of facility personnel or other appropriately licensed entity shall not be subject to these limitations, and may be admitted or permitted to continue as a resident in an assisted-care living facility:

(i) Nasopharyngeal or tracheotomy aspiration;

(ii) Nasogastric feedings;

(iii) Gastrostomy feedings; or

(iv) Intravenous therapy or intravenous feedings.

(E) Notwithstanding any other provision of this subdivision (5), any assisted-care living facility resident who qualifies for hospice care shall be able to receive hospice care services and continue as a resident of the assisted-care living facility so long as the resident's treating physician certifies that hospice care can be appropriately provided at the facility. In addition, the hospice provider and the assisted-care living facility are jointly responsible for the development of a plan of care that ensures the safety and well-being of the resident's living environment and for the provision of the resident's health care needs. Furthermore, the hospice shall be available to assess, plan, monitor, direct and evaluate the resident's palliative care in conjunction with the resident's physician and in cooperation with the assisted-care living facility.

(F) The board for licensing health care facilities shall not promulgate any regulation, make any determination, issue any waiver, take any action or refuse to take action that has the effect of permitting an assisted-care living facility to provide care to persons or to admit or permit the continued stay of such persons except in accordance with this subdivision (5).

SECTION 23. Tennessee Code Annotated, Section 68-11-213(i), is amended by adding as a new subdivision (3) the following language, "The board for licensing health care facilities is authorized to establish as part of its comprehensive system of quality assurance and enforcement a system for assessing civil monetary penalties, including appropriate due process, for assisted-care living facilities that are in serious violation of state laws and regulations, resulting in endangerment to the health, safety, and welfare of residents;" the remaining subdivisions shall be renumbered accordingly.

SECTION 24. The board for licensing health care facilities is authorized to promulgate rules and regulations pertaining to licensure of assisted-care living facilities as set forth in Sections 21 through 23 of this act, including any changes necessary to ensure the health and safety of assisted-care living facility residents with higher levels of need. All such rules and regulations shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act compiled at Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 25. Any managed care organization providing long-term care services shall be subject to the same requirements regarding prompt payment of claims, and the additional liability for bad faith failure to pay claims promptly, as are applicable under the provisions of § 56-32-226, as may be amended, and any regulations relating thereto.

SECTION 26. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

71-5-__01.

(a) In order to improve planning for facilities and programs, to create a better environment for management, and to ensure implementation of proposed improvements in the long-term care services system, there is hereby created the Select Oversight Committee on Long-Term Care, hereafter referred to as "the committee."

(b) The committee shall be composed of ten (10) members, with five (5) members to be appointed by the Speaker of the Senate and five (5) members to be appointed by the Speaker of the House of Representatives.

71-5-__02.

(a) The committee shall elect from its membership a chair, a vice chair, and such other officers as it considers necessary.

(b) The committee may also:

(1) Create subcommittees related to its purposes;

(2) Request that standing committees of the general assembly, the fiscal review committee, or other agencies study certain aspects of the long-term care services system and report to the committee;

(3) Conduct hearings;

(4) Employ staff, subject to the availability of funds;

(5) Enter contracts for technical or professional services, subject to the availability of funds; the Speaker of the Senate and the Speaker of the House shall jointly determine the qualifications and task or job descriptions of any consultant or other person contracted for services, and shall jointly select any such consultant or other person on behalf of the committee; and

(6) Perform such other duties as are required.

71-5-__03.

(a) The committee shall meet at least quarterly and at the call of the chair. The first meeting of the committee shall be convened by the Speaker of the House.

(b) Members of the committee are entitled to be reimbursed for their expenses in attending meetings of the committee or any subcommittees thereof at the same rates and in the same manner as when attending the general assembly.

71-5-__04. The committee shall report on its activities to each member of the general assembly.

71-5-__05.

(a) It is the intent of this part that plans be made carefully and be reviewed thoroughly to help ensure that new programs will achieve their intended purposes, and to help ensure that the general assembly and the public can have confidence that the state will deliver a long-term care services system with a home and community-based services component which is effective and efficient.

(b) To these ends, the committee shall review proposed expenditures and program proposals for long-term care and shall make its comments on proposed expenditures and program activities in a timely fashion according to the following:

(1) Any proposed expenditure of funds to implement new programs or expand existing programs, and any administrative or management changes requiring additional expenditures, shall be filed in writing by the Commissioner of Finance and Administration with the committee and may be reviewed by the committee. After any such review, the committee may comment to the Commissioner of Finance and Administration on the proposed expenditures; provided, that any such comment shall be made within thirty (30) days after receipt by the committee of the proposal for such expenditures. If such expenditures are made before the committee has made its comments, if any, or if expenditures are made which are inconsistent with the comments of the committee, the Commissioner of Finance and Administration shall explain in writing the reasons for making such expenditures to the committee and each other member of the general assembly.

(2)(A) Subject to subdivision (B), any proposed federal waivers or waiver amendments and any contracts and amendments involving risk based contractors or managed care organizations shall be filed in writing by the Commissioner of Finance and Administration with the committee at the least thirty (30) days before it is filed or submitted to the federal government or entered into with a contractor. The committee has the authority to review such plans and proposals and, after such review, the committee may comment to the Commissioner of Finance and Administration and the commissioner is encouraged to consider the

committee's comments, if any, in making its decisions.

(B) Before the Commissioner of Finance and Administration may submit a request for a new waiver, an amendment to the waiver or a renewal of the waiver for the TennCare program to the United States Department of Health and Human Services, the commissioner shall transmit such proposed waiver, renewal or amendment to the committee in writing for comment at least thirty (30) days prior to submission of the waiver to the Department of Health and Human Services. No such waiver, amendment or renewal request may be submitted or take effect unless the committee has been afforded the opportunity to comment. Since such waiver, amendment or renewal requests are legally enforceable when they take effect, the committee shall review such waivers, amendments or renewal requests in the same manner as proposed legislation, subject to the thirty-day period required by this subsection.

(3) Any proposed rules for implementing any provision of this act, except for emergency or public necessity rules, shall be filed in writing by the Commissioner of Finance and Administration with the committee at the least thirty (30) days before it is filed or goes into effect. No such rules may be submitted to the secretary of state or take effect unless the committee has been afforded the opportunity to comment. The committee has the authority to review such rules and, after such review, the committee may comment to the Commissioner of Finance and Administration and the commissioner is encouraged to consider the committee's comments, if any, in making its decisions. This rule review is separate from any rule review pursuant to Title 4, Chapter 5.

71-5-__06. The committee shall receive information and assistance from the Department of Finance and Administration, the Department of Health, the Commission on Aging and Disabilities, the Department of Human Services and other agencies of state government, as necessary.

71-5-__07.

(a) When a bill is introduced in the general assembly that will impact or potentially impact upon any area within the scope of review of the committee, committee staff, at the direction of the chair, shall identify such bill for review. For purposes of participating in the discussions and comments of the committee,

the chair or the chair's designee of the appropriate standing committee shall be notified of the date, time, and location where the committee will meet to review legislation and such chair or the chair's designee shall become an ex-officio member of the committee when such legislation is considered by the committee.

(b) In order to efficiently execute the duties set out in this part, the committee shall review all bills identified pursuant to subsection (a), and may attach committee comments to such bill prior to its consideration by the appropriate standing committee. The sole purpose of review by the committee is to assist the standing committee in its consideration of long-term care legislation by providing appropriate background information on the bill or information concerning the impact of the bill on the long-term care system. The committee shall make no recommendation concerning the passage of a bill it reviews nor shall it have the authority to prevent the consideration of the bill by the standing committee to which it is referred. The committee's review of all bills identified pursuant to subsection (a) shall be completed and the notification required in subsection (c) returned to the chair of the appropriate standing committee no later than four (4) weeks after a bill covered by the provisions of this section has first been introduced.

(c) Upon completion of the review process within the time limitation established in subsection (b), the chair of the committee shall send written notification to the chair of the appropriate standing committee indicating that the review process has occurred and that the bill is ready for consideration by the standing committee. If the committee has prepared committee comments on a bill, such comments shall be attached to the notification to the chair. If the committee has reviewed a bill but has no committee comments, that shall be indicated in the notification to the chair. If a bill is referred to the committee for review but has not been reviewed within the time period set out in subsection (b), the chair shall notify the appropriate chair that the bill has not been reviewed but is ready for consideration by the standing committee.

71-5-__08.

(a) For the purposes of this part, "managed care organization" and "MCO" mean any health maintenance organization, behavioral health organization, any entity regulated pursuant to Title 56, Chapter 32, and contractors of such entities.

(b) The committee shall review regularly the following long-term care services-related programs, functions and activities of the Department of Health, the Commission on Aging and Disabilities, the Department of Human Services and the TennCare program:

(1) Eligibility and enrollment standards, including determinations of how long-term services recipients are assigned to MCOs, or other matters related to eligibility and assignment of TennCare enrollees and participants in the Options program established by Part 14;

(2) Provisions of services, facilities or programs by TennCare and Options providers, including benefit packages or other related matters;

(3) Education programs for TennCare and Options enrollees, MCOs and providers, including eligibility, access to providers and MCOs, benefit package offered, deductibles and co-payments required or other related matters;

(4) Review and evaluation of performance of MCOs, including their compliance with contracts entered into with the state, review of MCO contracts entered into with any long-term care services provider or other related matters;

(5) Compliance by the appropriate agencies with provisions of applicable federal waivers, including review of proposed amendments to the waiver for system changes, and evaluations or reports prepared for or by the federal government, or other related matters;

(6) Staffing within the department, including recruitment, selection, training, compensation, discipline or other matters;

(7) Management, including planning, budgeting, information systems, organizational structure, rules and regulations, department policies and procedures or other related matters; and

(8) Any other matters considered material.

71-5-__09. The committee created by this part will terminate at the adjournment of the regular session of the general assembly convened in 2013. The general assembly may continue the committee for five (5) years by appropriate action during such regular session.

71-5-__10. Notwithstanding any provision of Title 3, Chapter 15, Part 5, the Select Committee on TennCare shall no longer have authority for oversight of long-term care in the TennCare program and all such oversight authority shall be vested in the Select Oversight Committee on Long-Term Care.

SECTION 27. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 28. This act shall take effect on July 1, 2008, the public welfare requiring it.

PASSED: May 20, 2008



RON RAMSEY
SPEAKER OF THE SENATE



JIMMY NAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES

APPROVED this 17th day of June 2008



PHIL BREDESEN, GOVERNOR